Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
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Original Public Report

Report Issue Date: January 9, 2023	
Inspection Number: 2022-1057-0003	
Inspection Type: Follow up Critical Incident System	
Licensee: Norwood Nursing Home Limited	
Long Term Care Home and City: Norwood Nursing Home, Toronto	
Lead Inspector Rodolfo Ramon (704757)	**Inspector Digital Signature**
Additional Inspector(s) Slavica Vucko (210)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): December 20-23, 29, 2022

The following intake(s) were inspected:

- Intake: #00002722-[CIS #2201-000005-21] related to a fall incident resulting in injury.
- Intake: #00011300-[CIS #2201-000013-22] related to a fall incident resulting in injury.
- Intake: #00013125-[CIS #2201-000014-22] related to resident to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management
Staffing, Training and Care Standards
Prevention of Abuse and Neglect
Responsive Behaviours

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INSPECTION RESULTS

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be **COMPLIED**.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 246/22	s. 249 (1) 1	2022-1057-0002	001	210
O. Reg. 246/22	s. 250 (1) 4	2022-1057-0002	002	210

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non compliance with: O. Reg 246/22 s. 102 (2)(b).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed as it related to hand hygiene practices and ensuring all hand hygiene agents are at least 70-90%.

During IPAC observations in the home, an expired sanitizer was identified outside of a dining area. Staff #111 verified that according to the manufacturer, the expired sanitizer was not as effective as 70% or more alcohol. The IPAC lead confirmed that this sanitizer was identified and replaced.

The use of expired ABHR reduced the effectiveness of the ABHR used in the home's hand hygiene program.

Sources: Observations and review of hand sanitizer label, interview with the IPAC lead.

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Date Remedy Implemented: December 29, 2022

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non compliance with: O.Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that procedures for cleaning and disinfection using, at a minimum, a low level disinfectant is implemented.

During IPAC observations, housekeeper #108 was observed disinfecting high touch surfaces with a bleach solution. According to the administrator, the concentration of bleach used in the home was calculated to be 500ppm.

The licensee's Environmental Policy indicated that cleaning and sanitizing of all equipment and furnishings in the home was to be completed in accordance with established best practice guidelines. The Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings referred to in the licensee's policy stated that 1000ppm concentration of bleach was required for low level disinfection.

The administrator verified the current concentration being used in the home did not comply with evidence based practices. On December 29, 2022 the administrator informed the inspector the concentration of the low level disinfectant was corrected.

This resulted in the inadequate implementation of the IPAC program.

Sources: Observations, Environmental Manual policy number ENV-III-02 last reviewed on May 12, 2020, PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, interviews with housekeeper #108 and the administrator.
[704757]

Date Remedy Implemented: December 29, 2022

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure residents were protected from abuse by anyone.

Resident #002 had an inappropriate physical interaction with resident #003. The incident was not witnessed, staff had to intervene to separate the two residents. Resident #003 was stressed and sustained an injury. On a separate date, at a similar time and location, resident #002 and resident #003 had a verbal altercation, because resident #003 commented inappropriately to resident #002.

Failure from the home to protect resident #003 from resident #002's physical abuse placed the residents at risk of injury.

Sources: Review of CIS report #2201_000014-22 and resident #002's clinical record, interviews with staff, resident #002 and #003.
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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, that behavioural strategies were developed and implemented to respond to these behaviours, where possible.

Resident #002 had an inappropriate physical interaction with resident #003. The incident was not witnessed, staff had to intervene to separate the two residents. Resident #003 was stressed and sustained an injury.

On a separate date, at a similar time and location, resident #002 and resident #003 had a verbal altercation, because resident #003 commented inappropriately to resident #002. RN #104 separated the residents and advised resident #003 if they were commenting to resident #002, it will cause an altercation.

As per the home's policy "Responsive Behaviour and Management", the team members have to identify

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the behaviour, triggers and interventions to manage responsive behaviours.

Resident #002 was admitted with responsive behaviours, identified triggers and physical aggression. Staff were to approach them with positive reinforcement.

Resident #002's care plan did not identify strategies to manage their responsive behaviours caused by resident #003's comments. There were no interventions developed and implemented to make sure resident #002's responsive behaviour did not trigger resident #003.

Failure from the home to develop and implement strategies to manage the triggers for resident #002's responsive behaviour led to the escalation of their behaviour, creating an unsafe environment for other residents.

Sources: Review of home's policy "Responsive behaviour, NUM-VII-33, observations, resident #002's clinical record, interview with resident #002, #003 and staff.
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